Claim Form

E-mail, fax, or mail completed form and itemized verification to third-party administrator. Instructions on reverse. Fillable version at **veba.org**.

VEBA Plan Third-party Administrator
Meritain Health | PO Box 27810 | Minneapolis, MN 55427-0810 | Phone: **1-888-828-4953** | Fax: **(763) 582-3470** | E-mail: **myclaims@meritain.com**

veba TRUST

1. PARTICIPANT INFORMATION

Last Name _____ First Name _____ Participant Account No. or SSN _____

E-mail Address (home or personal recommended) _____ ☐ Check here if new e-mail address

(_____) _____-_____ Area Code and Phone Number

Mailing Address _____ ☐ Check here if new address City _____ State _____ Zip _____

2. OUT-OF-POCKET EXPENSES AND PREMIUMS

NOTE: Federal law requires the third-party administrator to have on file the full name, Social Security number, gender, and date of birth of all covered individuals.

1

Patient (covered individual) information

First Name _____ M.I. _____ Last Name _____

Date of Birth (mm/dd/yyyy) _____ Gender _____ Social Security Number _____

Relationship to participant

☐ Self ☐ Qualifying child
☐ Spouse ☐ Qualifying relative
☐ Other:_____

Expense type(s) [check one, or more if submitting multiple expense types for this covered individual]

☐ Medical co-pay ☐ Medical out-of-pocket ☐ Dental / Ortho ☐ Premium
☐ Medical deductible ☐ Prescription (Rx) ☐ Vision ☐ Other: _____

Total out-of-pocket for this covered individual

$☐☐,☐☐☐.☐☐

2

Patient (covered individual) information

First Name _____ M.I. _____ Last Name _____

Date of Birth (mm/dd/yyyy) _____ Gender _____ Social Security Number _____

Relationship to participant

☐ Self ☐ Qualifying child
☐ Spouse ☐ Qualifying relative
☐ Other:_____

Expense type(s) [check one, or more if submitting multiple expense types for this covered individual]

☐ Medical co-pay ☐ Medical out-of-pocket ☐ Dental / Ortho ☐ Premium
☐ Medical deductible ☐ Prescription (Rx) ☐ Vision ☐ Other: _____

Total out-of-pocket for this covered individual

$☐☐,☐☐☐.☐☐

3

Patient (covered individual) information

First Name _____ M.I. _____ Last Name _____

Date of Birth (mm/dd/yyyy) _____ Gender _____ Social Security Number _____

Relationship to participant

☐ Self ☐ Qualifying child
☐ Spouse ☐ Qualifying relative
☐ Other:_____

Expense type(s) [check one, or more if submitting multiple expense types for this covered individual]

☐ Medical co-pay ☐ Medical out-of-pocket ☐ Dental / Ortho ☐ Premium
☐ Medical deductible ☐ Prescription (Rx) ☐ Vision ☐ Other: _____

Total out-of-pocket for this covered individual

$☐☐,☐☐☐.☐☐

NOTE: If your account is allocated among multiple investment funds, withdrawals (claims) will be deducted pro rata based on your balance in each fund at the time of withdrawal unless you request otherwise.

GRAND TOTAL for this form → $☐☐,☐☐☐.☐☐

3. PARTICIPANT SIGNATURE (required)

I hereby certify that (1) the information provided in this claim request is true and correct; (2) the amount of this submitted claim to the Third-party Administrator is an accurate statement of my unreimbursed medical/dental/vision expenses and/or medical/dental/vision/tax-qualified long-term care insurance premiums; and (3) the submitted claim is not reimbursable from any other source. With respect to claims submitted on behalf of qualified dependents, I hereby certify that such person meets the Plan requirements as summarized on the reverse and is a qualified dependent as defined under the terms of the Plan. With respect to claims for qualified insurance premiums, I hereby certify that such premiums have not been paid by my employer and are not eligible for pre-tax deduction through my or my spouse's section 125 cafeteria plan.

Required itemized verification attached (see instructions on reverse)? ❑ **Yes** ❑ No

X _____ _____

Participant Signature Date

INSTRUCTIONS FOR SUBMITTING CLAIMS

Use this form to request reimbursement of qualified healthcare expenses and/or insurance premiums you have incurred on behalf of yourself, your spouse, and/or your eligible dependents (fillable version available at **veba.org**). Qualified expenses and premiums submitted for reimbursement must have been incurred after you became a participant eligible to file claims. Want to see your claims in progress and claims history? Go to **veba.org** and click ***my*VEBA Plan *online*** to login to your account.

To expedite your claim:

1. **Fully complete all requested information**. Missing information may delay the processing of your claim and could result in your claim being denied. Don't forget to sign and date the form.
2. You must **attach itemized verification for each expense or service**. Generally, verification should contain (1) patient (covered individual) name; (2) date item was purchased or service was provided; (3) description of expense or service; and (4) out-of-pocket amount. Acceptable forms of verification include (1) an explanation of benefits (EOB); (2) an itemized billing or statement from your provider; or (3) a detailed receipt for prescription or over-the-counter (OTC) medications. Cancelled checks and balance forward statements are not acceptable.
3. For qualified insurance premium reimbursement, you must attach documentation which includes the following: (1) name(s) of covered individual(s); (2) premium amount(s); (3) policy period; and (4) insurance provider name and address. This information is typically contained on your premium billing notice. NOTE: Premiums paid by an employer, or premiums that are or could be deducted pre-tax through your or your spouse's employer, are not eligible for reimbursement.
4. Sign up for direct deposit; its faster and more secure. Go to **veba.org** and click ***my*VEBA Plan *online***.

To set up systematic reimbursement of monthly insurance premiums, go to **veba.org** and click ***my*VEBA Plan *online*** to login to your account. Or, submit a completed **Systematic Premium Reimbursement Form**.

Questions? Contact the third-party administrator, Meritain Health, at **myVEBAPlan@meritain.com** or **1-888-828-4953**.

QUALIFIED EXPENSES AND PREMIUMS

Internal Revenue Code § 213(d) defines qualified expenses and premiums, in part, as "medical care" amounts paid for insurance or "for the diagnosis, cure, mitigation, treatment, or prevention of disease…" Expenses solely for cosmetic reasons generally are not eligible (e.g. facelifts, hair transplants, hair removal, etc.).

Common expenses include co-pays, coinsurance, deductibles, and prescriptions. Common insurance premiums include medical, dental, vision, tax-qualified long-term care (subject to IRS limits), Medicare Part B, Medicare Part D, and Medicare supplement plans. Go to **veba.org** to view a more extensive list.

Please note the following:

1. Insurance premiums paid by an employer, or premiums that are or could be deducted pre-tax through your or your spouse's section 125 cafeteria plan, are not eligible for reimbursement.
2. If you or your spouse have a section 125 healthcare flexible spending account (FSA), you must exhaust the FSA benefits before submitting claims.
3. Claims for over-the-counter (OTC) medicines and drugs should be for reasonable quantities expected to be consumed within a reasonable period of time. Sales tax can be included.

QUALIFIED DEPENDENTS

Generally, dependents must satisfy the IRS definition of **Qualifying Child** or **Qualifying Relative** as of the end of the calendar year in which expenses were incurred to be eligible for benefits. These requirements are defined by Internal Revenue Code § 152 and described in IRS Publication 502. These definitions supersede and may differ from state definitions. Go to **veba.org** for more information.

Qualifying Child. A qualifying child is a child who: (1) is your son, daughter, stepchild, foster child, brother, sister, stepbrother, stepsister, or a descendant of any of them (for example, your grandchild, niece, or nephew); and (2) at the end of the calendar year in which expenses were incurred will be (a) under age 19, or (b) under age 24 and a full-time student, or (c) permanently and totally disabled; and (3) is younger than you; and (4) is unmarried; and (5) lives with you for more than half the year; and (6) does not provide more than half of his or her own support; and (7) is a citizen, national, or resident of the U.S. or a resident of Canada or Mexico.

Qualifying Relative. A qualifying relative is a person who: (1) is your (a) son, daughter, stepchild, foster child, or a descendant of any of them (e.g. your grandchild); or (b) brother, sister, or a son or daughter of either of them; or (c) father, mother, or an ancestor or sibling of either of them (for example, your grandmother, grandfather, aunt, or uncle); or (d) stepbrother, stepsister, stepfather, stepmother, son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, or sister-in-law; or (e) any other person (other than your spouse) who lived with you all year as a member of your household; and (2) will not be a qualifying child of any other person as of the last day of the calendar year in which expenses were incurred; and (3) does not provide more than half of his or her own support; and (4) is a citizen, national, or resident of the U.S. or a resident of Canada or Mexico.